Preliminary Report to the Legislature
Child Residential Treatment Services Program
Section 11.19
And
Out of Home Placement Section 11.21
Of House Bill 1840

Section 11.19 (a), The Child Residential Treatment Services Program and Section 11.21(a), Out of Home Placement funding addressed children with similar needs and also had similar requirements. Due to the overlapping of the provisions and in order to achieve the purposes and goals of both provisions, the two provisions have been used to implement a coordinated delivery approach for children's services, referred to as the "New Beginnings." The New Beginnings utilizes a System of Care approach that provides a comprehensive spectrum of mental health and other necessary services and supports, organized into a coordinated network to meet multiple and changing needs of children with mental health needs and their families. The System of Care Approach is widely acknowledged to be the best practice model for effectively integrating services and resources for these children and their families.

The System of Care is child and family centered and is community based. This approach provides a standardized framework families can count on for coordinated interagency service delivery, a primary individualized treatment plan, core array of local and regional supports and services, continuity of care across agencies and providers and early intervention and prevention. In addition, it provides a template for accountable local interagency resource management in the community promoting local creativity for building upon each family's strengths and needs. This is accomplished by integrating front line services; system level polices and programs, sharing resources and accountability across agencies, advocates, private providers and community resources.

In order to accomplish this approach, the Department of Health and Human Services (DHHS) and the Department of Juvenile Justice and Delinquency Prevention (DJJDP) formed a state Collaborative for Children and Families to develop, operationalize and implement the program. This collaborative consists of staff from the Division of Mental Health/Developmental Disabilities/Substance Abuse Services, Division of Social Services, Division of Medical Assistance, DHHS Controller's Office, DJJDP Youth Development Division (Training Schools and Detention Centers), Intervention/Prevention (Court Services)**,** Department of Public Instruction, family and child advocates and other stakeholders. Community Collaboratives have been formed at the local level that consists of staff from local Department of Social Services, Area Mental Health Programs, and Juvenile Court Counselors. Although not required through legislation, the State Collaborative has encouraged additional agencies such as schools, health departments, private providers, families, advocates and other local community stakeholders to participate in the local Collaboratives. These Collaboratives work

together on policy implementation, fiscal management concerns, and utilization review among other issues.

Memorandums of Agreements have been signed by the state agencies and at the local level between area programs, social services and juvenile justice. These agreements outline the duties and responsibilities of all the agencies involved. A work group continues to meet to refine existing agreements in order to implement a single local Memorandum of Agreement between the local courts, youth academies, area programs, and social services effective July 1, 2001.

In addition to signed Memorandum of Agreements, tasks which have been accomplished in order to achieve the implementation of New Beginnings include.

- Behavioral Health Screening tools and procedures were adopted and implemented for children receiving DSS services, those in DSS custody, Medicaid eligible children, and children residing in the youth academies. Screening for children in the juvenile court system will be accomplished by using the statutorily mandated Risk/Needs tool developed by DJJDP.
- Psychiatric Residential Treatment Facility (PRTF) was added to the continuum of Medicaid covered services effective October 1, 2000. Both the service definition, utilization review criteria, rates, and eligibility were standardized across funding sources and agencies. Four training sessions were conducted across the state for clinicians and providers. Technical assistance continues to be provided to agencies in order to develop specialized programs for target populations.
- Roles and responsibilities have been established for case management among the various agencies. This includes multidisciplinary case management.
- Administrative functions of local public agencies and state agencies have been clarified. Allocation procedures of funding to address administrative functions of the local Collaboratives have been adopted across agencies.
- The former Willie M. class designation has been removed at the State and local levels. State appropriation for this class has now been designated for At-Risk children, which not only includes former Willie M. clients, but other children who face potential institutionalization or other out of home placement. Former Willie M. staff at the state level have been reassigned to other sections in the Division in order to accomplish other tasks required to implement the provisions. Examples of these tasks include state monitoring of providers instead of reviews by multiple area programs and specific client specific case consultations with local DSS offices, Juvenile Courts and area programs.
- Eligibility criteria, priority population and utilization review criteria have been adopted state wide and across funding sources. These funding sources include Medicaid, state appropriations (including former Willie M. funds) and Health Choice. This is one of the mechanisms instituted to ensure that children are not placed in the custody of social services for the purpose of obtaining residential treatment services.
- Common referral procedures and access standards were established and implemented across agencies. Local, regional and state staff (DSS, DMH/DD/SAS and DJJDP)

across participating agencies have been identified to triage and manage intensive, specific cases.

- Residential providers of High Risk Residential Services Level 2, Level 3, and Level 4 with 4 or more beds were allowed to begin enrolling directly with the Division of Medical Assistance effective January 1, 2001 and full implementation by July 1, 2001. Direct enrollment of other residential providers is planned for the future.
- The same rate structure has been adopted for Medicaid and nonMedicaid covered High Risk Intervention Residential Services for Levels 2 through 4 and for Psychiatric Residential Treatments Facilities (PRTFs). As a result of a comprehensive rate study, rates were adjusted across funding sources for residential services. Common cost reports were developed and implemented for use in FY 00-01. The rate study included the analysis of treatment and room and board costs. In addition to mental health services and Medicaid services, policy guidance was issued regarding the utilization of IV-E funds and foster care funds. Providers of comparable levels of residential services must accept the state rates as payment in full.
- Reviews and monitoring of direct enrolled providers has become a coordinated state function and is no longer a function of multiple local agencies. This reduces administration and inconsistency among various contracting local agencies.
- A communication and training plan has been developed in order to cross train staff and families and to promote communication across public and private agencies. This included conducting three statewide training sessions, training over 1000 providers, families and agency staff in the implementation of New Beginnings. Additional follow up training has been scheduled and planned. This includes regional joint administrative staff meetings among DJJJP, DSS and DMH/DD/SAS as well as training opportunities. All communications from the state offices are distributed across public agencies and state collaborative members. The Division of MH/DD/SAS maintains a web site for access to communication for families, providers and other interested parties.
- Allocation formulas for both direct clinical/support services and administrative functions have been established and implementation is planned for March 1, 2001.
- Development of a family information packet has been completed. This includes a family handbook and other agency reports for families to use to assist them in decisions and the coordination of services.

As the program was being developed and implementation began, barriers have evolved that require further action and study. In order deal more effectively with the concerns and problems, the State Collaborative meets weekly. The major barriers identified include:

- Rules, policies, procedures and guidelines from the major divisions and departments were identified during the development and implementation that did not support the mission of children's mental health services or the intent of the legislation. Examples of these included licensure standards, funding limitations, staffing qualifications and contracting practices. This identification process delayed the implementation of initial action steps to establish a more effective and integrated system of services for the target population. Furthermore, once identified, the action required to correct or alleviate the problems involved many steps, some of which included rule making

procedures. Although temporary rule status was granted, gathering and analyzing information, as well as, gathering input from the various stakeholders has caused delays in implementation. This issue continues to be major focus and will be an ongoing challenge. Once the rule and policy simplification has been achieved the outcome will be significantly more beneficial to the overall service delivery for children and their families.

- The cross agency collaboration has also caused a shift in the longstanding practices of both public and private providers. Some agencies do not support the change in policy or philosophy; i.e. moving toward shared responsibility and accountability. This approach requires changes in organizational structure and staff, duties requiring collaboration and trust among agencies or stakeholders that may not have worked together or had positive relationships in the past.
- Establishing mechanisms to ensure coordination of verbal and written communication to all effected parties that have previously operated separately is a necessary developmental process. Although communication has been a priority, keeping all effected parties informed in a timely manner has been a major task. This included communication among all state and local agencies. These factors impacted availability of funding and allocations as a more integrated approach was established.
- Procedures and documentation for eligibility and service planning need further refinement. The need to combine child mental health requirements with the remaining Willie M requirements along with the requirements for the social service departments has caused some duplication. Streamlining the process and requirements will continue to be reviewed and implemented in a concerted manner. Both the state and local agencies are involved in this process and support this objective.
- Delays in the establishment of the state staff positions and reclassification of existing positions caused existing staff to assume additional duties that effected the timeliness of tasks. The recent budget and personnel restrictions have had direct impact on the ability to provide training and technical assistance as needed and required for successful implementation of the program components across agencies.
- The state budget deficit has caused significant reductions in technical assistance, staff training and duplication of materials.
- The development of the local and state infrastructure to necessary to ensure shared responsibility, accountability and inclusion of stakeholders is complex. This requires both the clinical and administrative reorganization and reassignment of staff. Clarification of duties of local collaboratives, liabilities and implementation of the changes in the structure has taken time. Even in a stable environment, this change would have been a major organizational change but given the environment of the mental health reform and budget deficits, delays have been more than expected.
- Service capacity at the local community level continues to be fragmented and under developed. Intensive wraparound and specialized residential services to divert inappropriate institutionalization continue to need network development. Out of state placements have occurred for children in order to secure appropriate treatment options. Recruitment and provider development continues to be a targeted area, as does efforts to increase family involvement.
- Although technology allows for a more seamless system, changes required among existing management information systems are expensive and must be planned in the

overall plan of technology for the state. Due to this, temporary measures have been made that are not the most efficient or effective for the long term. Examples include continued payment from more than one agency and reporting of client specific data by more than one agency in order to gather all the required elements. The long-range plan continues to be a single payment process with sharing of relevant client specific information utilizing a statewide interactive database with proper security controls.

- The technology challenges require the use of submitted reports from the local level instead of availability of on line data in real time.
- The dissolution of the Willie M program has caused concern among various stakeholders. Although advocates support the availability of services to more children, the loss of the entitlement to those services has caused anxiety for families of the former Willie M. clients. All stakeholders are concerned about the amount of funding available to meet the overall needs of children who have behavioral health needs.
- Although participation has been encouraged for local education agencies and the Department of Public Instruction, the absence of their presence in the legislation has led to questions and expressed concern.

Despite these barriers, there are currently approximately 1560 children being served in residential services. This number does not include children who are receiving at risk funding for nonresidential community-based services. In general, state and local agency staff are committed to a more collaborative approach and believe this to be a more effective approach to meet the needs of children with mental health needs and their families. Further, family members who have experienced with the System of Care approach are enthusiastic advocates in support of New Beginnings.